REQUEST FOR CHAMPUS BENEFITS UNDER THE PROGRAM FOR PERSONS WITH DISABILITIES

Form Approved
OMB No. 0704-0098
Expires Sep 30, 1992

Privacy Act Statement

AUTHORITY: EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE(S): To determine CHAMPUS eligibility

ROUTINE USE(S): To locate and correspond with sponsor, determine appropriateness and cost of care, and issue written approvals and authorized payment of claims.

DISCLOSURE: Voluntary; however, failure to provide the information will result in denial of the benefits

PART I - INSTRUCTIONS TO SPONSOR

a. ALL INFORMATION ON BOTH SIDES OF THIS FORM MUST BE COMPLETED PRIOR TO APPROVAL FOR PAYMENT OF BENEFITS

b. PROGRAM FOR PERSONS WITH DISABILITIES BENEFITS ARE LIMITED TO SERIOUSLY PHYSICALLY HANDICAPPED OR MODERATELY/SEVERELY MENTALLY RETARDED DEPENDENTS OF ACTIVE DUTY MILITARY PERSONNEL

c. TRANSPORTATION IS A BENEFIT AVAILABLE ONLY UNDER THE PROGRAM FOR THE HANDICAPPED AND ONLY IF THE FACILITY TO WHICH THE PATIENT IS TAKEN IS EITHER PUBLIC OR NON-PROFIT PRIVATE

d. UNDER THE PROGRAM FOR PERSONS WITH DISABILITIES, THE SPONSOR PAYS AN INITIAL SHARE OF THE MONTHLY COST ACCORDING TO SPONSOR'S PAY GRADE (SEE TABLE BELOW); THE AMOUNT PAIDE BY THE GOVERNMENT WILL NOT EXCEED $1,000 MONTHLY

SPONSOR PAY GRADE	AMOUNT/ MONTH	SPONSOR PAY GRADE	AMOUNT/ MONTH	SPONSOR PAY GRADE	AMOUNT/ MONTH
E-1 through E-5	$ 25	E-5, O-3, W-1, W-2	$ 45	O-7	$ 100
O-8	$ 30	W-3, W-4, and O-4	$ 50	O-8	$ 150
E-7 and O-1	$ 35	O-5	$ 65	O-9	$ 200
E-8 and O-2	$ 40	O-6	$ 75	O-10	$ 250

PART II - SPONSOR INFORMATION

1. SPONSOR'S NAME (Last, First, M)	2. RANK AND PAY GRADE	3. BRANCH OF SERVICE	4. SOCIAL SECURITY NUMBER (SSN)

5. COMPLETE MILITARY ADDRESS (Street, City, State, Zip Code)	6. HOME ADDRESS (Street, City, State, Zip Code)
TELEPHONE AREA CODE ( ) EXT	TELEPHONE AREA CODE ( )

PART III - PATIENT INFORMATION

7. PATIENT NAME (Last, First, M)	8. DATE OF BIRTH (YYMMDD)	9. RELATIONSHIP TO SPONSOR

10. HOME ADDRESS (Street, City, State, Zip Code)	11. IDENTIFICATION CARD NUMBER (DD Form 1173)
TELEPHONE AREA CODE ( )	MONTH / DAY / YEAR EFFECTIVE DATE EXPIRATION DATE

12. NAME AND ADDRESS OF CARE PROVIDER (Including Zip Code)	13. TYPE OF CARE (X one)	14. STATUS (X one)
	[ ] RESIDENTIAL [ ] NON-RESIDENTIAL [ ] MEDICAL EQUIPMENT	[ ] PUBLIC [ ] NON-PROFIT PRIVATE [ ] PROPRIETARY
	15. ESTIMATED COST OF CARE/EQUIPMENT $	

16. ANTICIPATED DATE OF ENROLLMENT AND/OR PURCHASE	17. TRANSPORATION (X one)	ESTIMATED MONTHLY COST OF TRANSPORATION
	[ ] PRIVATE CAR [ ] OTHER (Specify) [ ] COMMERCIAL MEANS	$

18. SIGNATURE OF SPONSOR, PATIENT, OR LEGALLY RESPONSIBLE PERSON	19. RELATIONSHIP TO PATEINT	20 DATE SIGNED (YYMMDD)

DIAGNOSTIC EVALUATION, PROGRAM FOR PERSONS WITH DISABILITIES

OFFICE OF THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
AURORA, COLORADO 80045-6900

Form Approved
OMB No. 0704-0098
Expires Sep 30, 1992

Privacy Act Statement

AUTHORITY: Defense Appropriations Act, EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To determine continued benefits under the CHAMPUS Program for Persons With Disabilities

ROUTINE USE(S): Provide diagnostic evaluation information for continued benefits under the Program for Persons With Diabilities

DISCLOSURE: Voluntary; however, failure to provide the information will result in denial of the benefits

SPONSOR'S SOCIAL SECURITY	DATE (YYMMDD)	PATIENT'S NAME (Last, First, Middle Initial)	SPONSOR'S NAME (Last, First, M.)

NAME AND ADDRESS OF PROVIDER OF CARE:

INTRODUCTION

PUBLIC LAW 89-614 (MILITARY MEDICAL BENEFITS AMENDMENTS OF 1968) REQUIRES US TO PERIODICALLY REVIEW ALL BENEFITS PROVIDED TO PHYSICALLY HANDICAPPED OR MENTALLY RETARDED PERSONS UNDER THE CHAMPUS PROGRAM FOR PERSONS WITH DISABILITIES. THE REVIEW IS USED TO DETERMINE WHETHER SERVICES PROVIDED HAVE BEEN EFICIENT AND EFFECTIVE. PLEASE COMPLETE BOTH SIDES OF THIS FORM, CONTINUING ON A SEPARATE SHEET, IF NECESSARY.

1 PROVIDE A BRIEF SUMMARY OF THE PATIENT'S CURRENT MEDICAL/MENTAL STATUS, INCLUDING A SPECIFIC DIAGNOSIS.

2. DESCRIBE CHANGES IN THE PHYSICAL OR MENTAL STATUS OF THIS PATIENT DURING THE PAST 12 MONTHS.

3. LIST THE MEDICAL/SURGICAL PROCEDURES PERFORMED DURING THE PAST 12 MONTHS, DESCRIBE OR ATTACH A COPY OF THE RESULTS OF ANY LABORATORY TESTS PERFORMED DURING THE LAST YEAR. IF AVAILABLE ATTACH A COPY OF THE MOST RECENT HISTORY AND PHYSICAL REPORT.

4. DESCRIBE THE PLAN OF MANAGEMENT PROPOSED FOR THIS PATIENT DURING THE NEXT YEAR.

5. IF THIS PATIENT IS PRESENTLY INSTITUTIONALIZED, DO YOU ANTICIPATE THAT (S)HE WILL EVER BE ABLE TO FUNCTION OUTSIDE OF THE INSTITUTION? IF YOUR RESPONSE IS YES, PLEASE INDICATE THE EXPECTED DATE OF DISCHARGE.

6. IF THIS PATIENT IS PRESENTLY RECEIVING A THERAPY I.E. OCCUPATIONAL THERAPY, PHYSICAL THERAPY, SPEECH THERAPY, STATE THE FREQUENCY OF THE TREATMENTS, THE EXPECTED GOALS AND ANTICIAPTED DATE OF COMPLETION.

7. COST OF CARE OR SERVICES PER MONTH	8. SIGNATURE OF ATTENDING PHYSICIAN	9. DATE (YYMMDD)

MAIL COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR

Public Official's Statement

Beneficiary Name (Last, First, MI)	Sponsor's Social Security Number

TYPE OF SERVICE	SERVICES REQUIRED	AVAILABLITY OF SERVICE FROM PUBLIC AGENCY *AVAILABLE	NOT AVAILABLE
Audiology	☐	☐	☐
Diagnostic Tests/Evaluations	☐	☐	☐
Education (RTC Psychiatric)	☐	☐	☐
Special Education	☐	☐	☐
Residential Care (Non-Psychiatric)	☐	☐	☐
Nursing	☐	☐	☐
Occupational Therapy	☐	☐	☐
Physical Therapy	☐	☐	☐
Durable Medical Equipment	☐	☐	☐
Hearing Aids	☐	☐	☐
Prosthetic Devices	☐	☐	☐
Other: (Specify) _____	☐	☐	☐

*Describe the Extent, Type, Frequency and Funding of each Available Service

Name and Title of Public Official (Typed or Printed)	Public Agency's Name and Mailing Address Zip Code

Signature of Public Official	Phone Number: ( )	Date

PRIVACY ACT STATEMENT

AUTHORITY:	10 U.S.C. 1079; E.O. 9397
PRINCIPAL PURPOSE(S):	To document the availability or lack of availability of specific medical services through publicly funded institutions and agencies in a medical service area. This statement is required for payment authorization of required services when the source of services must be other than a publicly funded facility. The statement must be submitted with DD Form 2532. Program for Persons with Disabilities applications, and must also accompany claims for certain specialty services under the CHAMPUS Basic Program.
ROUTINE USE(S):	None
VOLUNTARY OR MANDATORY DISCLOSURE AND EFFECTS ON INDIVIDUAL OF NOT PROVIDING INFORMATION:	Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim.

GENERAL INSTRUCTIONS ON PUBLIC OFFICIAL'S STATEMENT

The Civilian Health and Medical Program of the Uniformed Service (CHAMPUS) is a program of medical benefits provided under public law to a specified category of individuals. CHAMPUS benefits may be authorized when the required services are not available from public institutions or agencies. The Public Official's Statement (POS) documents the availability of certain publicly funded services. These services may be available through the local public school system or Title V of the Social Security Act funded programs such as Crippled Children's Services for children and services for adults may be available through the Public Health Department/Department of Vocational Rehabilitation.

The POS must be submitted along with the Program for Persons with Disabilities (PFPWD) Application, DD Form 2532 (formerly the CHAMPUS Form 190a), to the appropriate fiscal intermediary before benefits may be authorized. The POS is also required for some benefits under the Basic Program, such as speech therapy and educational services in a residential treatment center. You may wish to contact your local Health Benefits Advisor (HBA) at the nearest Military Treatment Facility for details.

Although similar in structure, CHAMPUS is not an insurance program nor is CHAMPUS subject to state regulatory bodies, agencies, or laws that control insurance business. CHAMPUS is first payor only to Medicaid/Medi-Cal (Title XIX of the Social Security Act).

If you need additional information concerning CHAMPUS, please contact your local HBA or fiscal intermediary.